



Spinal Ultrasound Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE.**

Patient/Member	First Name:		Middle Initial:	Last Name:		
	DOB (mm/dd/yyyy):			Gender:	Male	Female
	Street Address:				Apt #:	
	City:			State:	Zip:	
	Home Phone:		Cell Phone:		Primary Contact:	Home Cell
	Health Plan:		Member ID:		Group ID:	
	Ordering Provider	First Name:			Last Name:	
Primary Specialty:		TIN:	NPI:			
Physician Phone:			Physician Fax:			
Address:				Suite #:		
City:			State:	Zip:		
Office Contact:					Ext:	
Contact Email:						
Facility/Site		First Name:			Last Name:	
	Group/Site Name:					
	Primary Specialty:		TIN:	NPI:		
	Site Phone:			Site Fax:		
	Address:				Suite #:	
	City:			State:	Zip:	
	Procedure	Check all applicable CPT Codes:	76800			
Other:						
Diagnosis	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:					

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Clinical Information	1. Date of most recent office visit or other contact with physician:		Don't Know				
	2. Type of most recent documented contact with physician?						
	Hospital	Phone call with office staff					
	Office visit	Phone call with physician					
	Email	Don't Know					
	Other:						
	3. Has there been prior imaging (Ultrasound, CT, MRI, etc.) for this condition? Select all that apply.						
	No prior imaging	Prior CT					
	Prior Ultrasound	Other:					
	Prior MRI	Don't Know					
4. What is the main reason for this request?							
Known or suspected spinal tumor	Known or suspected spina bifida						
Known or suspected vascular malformation	Other known or suspected congenital spinal abnormality						
Known or suspected birth related spinal trauma	Other:						
Known or suspected tethered cord	Don't Know						
Additional Information/Comments:							
Submitter	Who is making this request?	Ordering Physician	Facility	Other:			
	Print Name:						
	Title:	MD	RN	LPN	PA	NP	Other:
	Signature:			Date:			